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THE TURNING POINT MODEL STATE PUBLIC HEALTH ACT[1]

MONTANA CODE AND ADMINISTRATIVE RULES ANALYSIS

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As of January 23, 2004

This document provides a brief analysis of Montana state code (MT Code) and the Administrative Rules of Montana (ARM) as they relate to the provisions of the Turning Point Model State Public Health Act (MSPHA).[2] The purpose of this analysis is to identify potential gaps in the MT Code and the ARM pertaining to public health (see below). While there are multiple gaps, some sections of MT state laws effectively approximate corresponding sections in the Turning Point MSPHA. For example, Montana's Health Care Information Act correlates with MSPHA Article VII (Public Health Information Privacy), though its application to public health data uses may be questionable (see below).

Information regarding the MT Code and the ARM was gathered from the legal search engines Lexis and Westlaw as well as the website of the Montana State Legislature. The MT Code and ARM were then compared to Articles II through VII of the MSPHA. Similarities and

[1] Professors Gostin and Hodge acknowledge **Jessica O'Connell**, JD/MPH Candidate, Georgetown and Johns Hopkins Universities, for her expert assistance with legal research and drafting.

[2] See http://www.publichealthlaw.net/Resources/Modellaws.htm for a complete copy.

differences were briefly described in the Montana Code and Administrative Rules Comparison Table (see separate document). Using this table, several potential gaps in the MT Code and the ARM are identified as briefly described below, and more fully explained thereafter:

- *Public Health v. Healthcare*: Considerable portions of the MT Code are devoted to health policy regarding access to and the quality of health care as opposed to the public's health [which is the predominant focus of the Turning Point Act].

- *Respect for Individual Rights/Due Process Guarantees*: MT state laws do not specifically address provisions respecting individual rights concerning public health services. Due process is guaranteed by the Montana Constitution but is not explicitly spelled out via statute or regulation related to public health actions.

- *Public Health Infrastructure*: There is little guidance in the MT Code or ARM related to public health infrastructure, certification, credentialing and training.

- *Relationships*: MT state laws do not specifically address relationships between the various state, tribal, or local health agencies within the state.

- *Prevention and Control of Conditions of Public Health Importance*: While the MT Code contains numerous disease-specific provisions, no section is generally devoted to public health powers regarding contagious diseases. The ARM also provides substantial guidance related to specific contagious diseases but does not provide overall guidelines for diseases or conditions of public health importance that are not specifically listed.

- *Surveillance*: While certain aspects of surveillance activities are required in the MT Code, it does not establish a surveillance system intended to track potential threats to the public's health.

- *Counseling and Referral Services*: MT state laws do not specifically provide for a counseling service pertaining to contagious diseases.

- *Testing, Examination and Screening*: The sections of the MT Code related to testing and screening only pertain to specific diseases.

- *Vaccinations and Immunizations*: The MT Code governs immunization requirements for school-age children but does not mention any other vaccinations or immunizations that could be essential to the public's health.

- *Public Health Emergencies*: While Title 10 of the MT Code is devoted to emergency planning, it is not specifically geared toward public health emergencies.

Public Health v. Healthcare

Initial sections of the MSPHA establish a mission for state and local public health agencies, which includes providing or assuring the provision of essential public health services

and functions.[3] These essential public health services and functions are enumerated in § 2-102 of the MSPHA.[4] They include developing public health policy, educating the public on matters of public health, and monitoring the community's health status. In addition, the MSPHA sets out the roles and responsibilities of the state's public health agencies and emphasizes the importance of respecting individual rights.[5] These foundational sections are critical to the rest of the Act in setting out guiding principles and overarching goals for the provision of public health services.

In contrast, the MT Code does not contain a fundamental mission statement focused on public health. Rather, it interchangeably uses the terms "public health" and "health care" throughout its public health provisions in Title 50. This can lead to confusion between two very different domains of health. Public health, as briefly defined in the MSPHA, means "assuring the conditions in which the population can be healthy."[6] "Health care" refers to "any care, service or procedure provided by a health care provider."[7]

An example of the potential conflict in using these two terms interchangeably in the MT Code is evident when comparing MSPHA § 2-101, Mission Statement, and MT Code § 50-4-104, State health care policy, which details Montana state policy related to health and safety. Section 50-5-104 is the only section of the MT Code that contains a health-related mission statement. While the MSPHA prescribes a mission of protecting the health of the public "to the greatest extent possible through the public health system,"[8] the MT Code describes Montana state policy as focused on "access to quality health services at costs that are affordable" and only briefly mentions public health concerns.[9] Lacking a more definitive mission statement, it is unclear what Montana's priorities are concerning public health.

Additionally, as discussed above, Montana's Health Care Information Act[10] centers on the responsibilities of health care providers in dealing with health care information. It does not, however, fully address how health care information should be handled in the realm of public health.

Furthermore, while state legislative policy is more focused on health care, the duties and responsibilities within the MT Code are focused on public health. The general powers and duties of the state health department include disease control, health education, and other public health services;[11] the powers delegated to local health officers and boards are similarly focused on public health.[12] In addition, certain communicable diseases, such as tuberculosis and STDs, are fully addressed.[13] The MT Code could be streamlined and Montana's priorities more easily identified if state legislation featured greater detail on public health issues.

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[3] MSPHA § 2-101
[4] MSPHA § 2-102
[5] MSPHA § 2-103
[6] MSPHA § 1-102(41)
[7] MCA § 50-16-504(4)
[8] MSPHA § 2-101(a)
[9] MCA § 50-4-104
[10] MCA § 50-16
[11] MCA § 50-1-202
[12] MCA § 50-2-118, 50-2-116
[13] MCA §50-17 and §50-18

Respect for Individual Rights/Due Process Guarantees

The Turning Point Act features a series of provisions related to respecting individual rights and guaranteeing due process. Section 2-103 requires that adequate due process be respected as an individual right.[14] Additionally, § 8-103 specifically addresses procedural due process and guarantees a hearing for all persons subject to formal or informal administrative adjudication.[15] This section provides further details of the aspects of procedural due process by requiring legal representation, timely notice, access to subpoenas and the right to appeal in the case of a trial. These provisions are essential for providing an avenue through which an individual can appeal actions taken by a state or local public health agency.

The MT Code does not provide similar due process guarantees regarding public health actions. It appears that Montana relies on its Constitution for due process guarantees whenever government action is taken.[16] While the Montana Constitution does guarantee due process[17] it does not spell out the procedures to be taken or how they apply to actions brought by public health agencies. For example, it is unclear what due process rights a citizen would have when placed in isolation or quarantine, or subjected to public health testing or screening.

The MT Code *allows* the state department of health to bring an action in court to enforce public health laws[18] but does not *require* the department to do so to protect individuals. A provision similar to MSPHA § 8-103, which specifically mentions each aspect of procedural due process,[19] may help ensure that due process guarantees secured by the MT Constitution actually applies when coercive action is taken by a state or local public health agency.

Public Health Infrastructure

The Turning Point MSPHA devotes much of Article III to issues concerning state and local public health infrastructure. Section 3-101 lists general goals of the public health system. Section 3-102 guides the certification and training of the public health workforce. Additional infrastructure issues that are statutorily addressed in MSPHA include performance management,[20] voluntary accreditation,[21] evaluations of the public health workforce,[22] public health planning and priority setting,[23] and a public health advisory council.[24] These provisions provide guidance as to the coordination of various entities within the public health system. While the MT Code speaks to some of these concerns, it does not address all of the issues discussed in Article III of MSPHA.

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[14] MSPHA § 2-103[c](3)
[15] MSPHA § 8-103
[16] Joan Miles. "An Overview of the Responsibilities and Authorities of Montana's Local Boards of Health"
[17] Montana Constitution, Article II, § 17
[18] MCA § 50-1-103
[19] MSPHA § 8-103
[20] MSPHA § 3-103
[21] MSPHA § 3-104
[22] MSPHA § 3-105
[23] MSPHA § 3-106
[24] MSPHA § 3-107

For instance, the MSPHA details how public health agencies on various levels should work jointly to accomplish various objectives for the public health system and lists several possible goals.[25] However, the MT Code does not provide specific public health goals. Instead, it lists the roles and responsibilities of health agencies individually. Listing goals for the entire public health system may help guide the actions of each public health agency.

Additionally, while the MT code details the responsibilities of health officers,[26] it does not mention certification or credentialing programs specific to the public health workforce similar to that discussed in the MSPHA.[27] These programs are designed to help ensure a uniform level of competency and training throughout the public health workforce.

Similar differences are found when comparing the remaining sections of the MSPHA Article III to Montana code. The MSPHA allows a state public health agency to establish performance standards within the public health system in order to monitor the quality of public health practice within the state;[28] provides for a state's participation in voluntary accreditation programs on the national and local levels;[29] and requires the state public health agency to implement a system to evaluate progress and allows the state to provide incentives for various public health goals.[30] Each of these sections provides guidance to the state public health department in monitoring and evaluating its progress towards overall goals for improving the public's health. However, the MT Code does not have any provisions that correspond to these three sections. The Code lists the powers and duties of both the state health department and local boards of health and health officers, but does not require or suggest that public health officials should also be involved in performance evaluation.[31] Along with establishing clear public health goals, Montana may consider establishing a system through which state officials can assess their public health policy and accomplishments.

Finally, sections 3-106 and 3-107 of the MSPHA describe a process for public health planning and priority setting, including a requirement for a comprehensive state public health plan to guide the public health system in meeting its goals,[32] essential elements of such a plan, and a description of a public health advisory council.[33] The comprehensive public health plan would be developed to set priorities for the public health system that meet the needs of its public and private sector partners. While Montana's state health care policy[34] sets health care priorities and references public health, it may not reflect a comprehensive plan geared specifically towards improving the public's health as envisioned in the MSPHA.

Additionally, it appears that Montana created a state health care advisory council,[35] but that it has since been repealed. Nevertheless, this council's responsibilities were focused on

[25] MSPHA § 3-101
[26] MCA § 50-1-202, 50-2-116, 50-2-118
[27] MSPHA § 3-102
[28] MSPHA § 3-103
[29] MSPHA § 3-104
[30] MSPHA § 3-105
[31] MCA § 50-1-202, 50-2-116, 50-2-118
[32] MSPHA § 3-106[a]
[33] MSPHA § 3-107
[34] MCA § 50-4-104
[35] MCA § 50-4-504

advising the health care system as opposed to public health workers. Consistent with other recommendations regarding Article III of the MSPHA, Montana may benefit from a defined system and planning process for determining priorities and goals of the state public health system.

Relationships

MSPHA Article IV describes various relationships within the public health system. It provides an overall discussion of relationships between and among federal, state, local and tribal public health agencies and allows agreements between the different agencies to provide essential public health services[36] and allows formal and informal working relationships and agreements between private and public sector partners and requires that the state public health department coordinate these relationships.[37] It also allows privatization of health services and functions with the goal of improving their delivery.[38] Additionally, Article IV discusses the relationships between health care providers, health care facilities and health insurers.[39]

Rather than addressing individual duties and responsibilities, Article IV delineates how the various entities of the state public health system should interact with one another and with other government agencies. It serves as a guide for fostering relationships with the goal of improving the provision of essential public health services and delegates specific responsibilities regarding those relationships to the state health department.

Montana Code addresses certain relationships within the realm of public health but only sparingly. Title 50, chapter 2 governs local boards of health and allows for the formation of city-county boards of health (an inter-local relationship).[40] The Code also allows counties to combine to form multi-district boards of health, though this organizational mechanism has been used sparingly. Currently, a group of 5 county health departments in central Montana are considering the creation of a district health board. However, the Code does not provide much detail nor does it mention inter-state or tribal agreements. Regarding relationships with entities in the private sector or public sector, the Code mentions three specific possibilities. The county attorney is required to serve as legal adviser to local boards of health,[41] law enforcement officials can assist public health officials in enforcing public health laws,[42] and public health officials can accept monetary contributions from other agencies.[43] It does not provide for relationships with the public and private sector in general, nor does it address the privatization of public health services.

A few sections of the Code discuss relationships within the health care system. Title 50, Chapter 5 (Hospitals and Related Facilities) governs certain aspects of the relationships between public health officials and health care facilities, such as licensing, inspections and reporting, but

[36] MSPHA § 4-101
[37] MSPHA § 4-102
[38] MSPHA § 4-102[e]
[39] MSPHA § 4-103
[40] MCA § 50-2-106
[41] MCA § 50-2-115
[42] MCA § 50-2-120
[43] MCA § 50-2-113

does not specify how such interactions should occur.[44] In addition, the Code describes the role of both Medicaid[45] and the State Children's Health Insurance Program[46] in the provision of essential public health services, but does not govern the involvement of other health insurers in providing assistance.

In summary, these assorted sections of the MT Code that apply to relationships within the public health system are disjointed and limited. A more cohesive description of the ways and needs of developing relationships within the system may be beneficial to ensure efficient provision of public health services.

Prevention and Control of Conditions of Public Health Importance

Article V of the MSPHA is about the powers and authority of public health authorities concerning conditions of public health importance. Its sections discuss in detail surveillance activities, reporting, epidemiologic investigations, counseling and referral services, testing, screening, compulsory treatment, quarantine/isolation, and vaccinations. Organized under this single Article, these sections help guide the actions of public health officials.

The Montana Code, however, does not speak definitively to how public health officials should handle conditions of public health importance. Local boards are granted the power to quarantine, isolate and furnish treatment to persons and can also adopt rules for the control of communicable diseases.[47] Local health officers must report communicable diseases and maintain quarantine and isolation.[48] However, these responsibilities are not comprehensive. Other sections of the Code detail duties with regard to specific contagious diseases. The Code has separate sections for tuberculosis[49] and sexually transmitted diseases,[50] describing testing, treatment, reporting procedures and quarantine for each disease.

The Administrative Rules also regulate the handling of contagious diseases in a very specific manner. Sections 37.114.501 to 37.114.592 (specific control measures) list a wide array of diseases and detail the minimum control measures that public health authorities must take with regard to each disease, including testing requirements, quarantine and isolation procedures, and necessary investigative actions. However, the Rules specify that if a reportable disease is not listed in subchapter 37.114, "no minimum control measures for the disease are required."[51] Certain diseases that have received recent public attention, such as SARS and smallpox, are not presently listed in 37.114. Regardless, local health authorities are required by the ARM to "investigate and take whatever steps are necessary" to prevent the spread of any reportable disease ("reportable disease" is defined by the ARM to include "any unusual incident of unexplained illness or death in a human or animal"[52]).[53]

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[44] MCA § 50-5-101 through § 50-5-116
[45] MCA § 53-6-101
[46] MCA § 53-4-1003
[47] MCA § 50-2-116
[48] MCA § 50-2-118
[49] MCA § 50-17
[50] MCA § 50-18
[51] ARM § 37.114.501(2)
[52] ARM § 37.114.203(bh)

This , disjointed, organizational approach inherent in MT state public health laws confuses and complicates the powers and authorities of state and local public health officers. It may be more efficient to list all general powers and responsibilities granted to local health officials in one section, as in Article V of the MSPHA.

Surveillance

Within Article V of the MSPHA, specific aspects of the prevention of conditions of public health importance are addressed. Section 5-102 explicitly speaks to surveillance activities and other sources of information related to public health.[54] Regarding the compilation of data, the MSPHA allows public health officials to collect and maintain data related to conditions of public health importance. Officials can obtain such data from governmental agencies, health care providers, and other organizations and the information can be identifiable as long as it is regarding a condition of public health importance. However, the data can only be used as dictated in Article VII of the MSPHA, which deals with health information privacy.

While the MT Code allows public health officials to request health information from public officials and corporations[55] it does not specifically delineate the bases or reasons supporting data collection or from what exact sources it can be obtained. The Code requires that data be used in a confidential and appropriate manner in the Health Care Information Act[56] though there is no direct reference to this Act in the Code section governing data requests. An enhanced section of the Code regarding surveillance activities that provided greater detail and guidelines as to how they should be undertaken may help.

Counseling and Referral Services

The MSPHA establishes a Counseling and Referral Services Program (CRS) with the intent of counseling any person potentially exposed to a contagious disease.[57] A CRS counselor is required to maintain confidentiality except when notifying a contact who was also potentially exposed to the disease. This section details the information that should be included in a contact notification and outlines when informed consent is required prior to notification. It also requires performance training and evaluation for all counselors employed by the CRS.

The Montana Code addresses partner counseling briefly, but does not provide for an overall counseling service. Regarding HIV/AIDS, the Code requires health care providers to give pretest counseling to the individual being tested for HIV and his or her guardian, next of kin or significant other.[58] The Code also allows a health care provider to disclose information without a patient's permission if the disclosure will avoid imminent danger to another contact.[59]

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[53] ARM § 37.114.314
[54] MSPHA § 5-102
[55] MCA § 50-16-101
[56] MCA § 50-16-5
[57] MSPHA § 5-105
[58] MCA § 50-16-1007
[59] MCA § 50-16-529(9); similar to MSPHA § 5-105[b](3)

However, these provisions only apply to health care providers and delegate very specific responsibilities regarding counseling and disclosure.

Thus, Montana does not feature a counseling service similar to the CRS with the intent of reaching a broader group of people. Legislatively authorizing this service may benefit those individuals exposed to a contagious disease who sought counseling and assist in identifying contacts who may benefit from notification of their potential exposure.

Testing, Examination and Screening

Article V of the MSPHA provides specific requirements and guidelines for testing, examination, and screening. Requirements for conducting these activities include individual informed consent, justification, predictive validity, and the provision of pre- and post-test information to participants.[60] The MSPHA also details different types of screening programs, including compulsory screening, conditional screening, and routine voluntary screening. These requirements and descriptions help ensure that testing and screening are conducted in a manner that respects individual liberties.

The MT Code addresses testing and screening in piecemeal fashion. The sections of the Code pertaining to compulsory testing and screening are very focused on a few diseases. There is no protocol for how and when to administer tests and when to screen individuals for certain diseases. Separate sections of the Code govern testing for AIDS,[61] tuberculosis[62] and sexually transmitted diseases[63] Each of these sections discusses conditions for mandated testing and requires informed consent. However, no guidance as to testing for other diseases is provided.

Additionally, the MT Code only seems to address screening in relation to mothers and children. It requires serological screening during prenatal exams[64] and metabolic screening of all newborns,[65] similar to examples of compulsory screening programs under the MSPHA. Yet the Code does not authorize public health officials to implement other types of screening programs where necessary nor does it mention informed consent or other individual considerations pertaining to screening or testing. Clearer descriptions of the roles and responsibilities inherent in testing and screening programs may improve implementation.

Vaccinations and Immunizations

The only section of the MT Code that mentions immunizations or vaccinations relates to state immunization requirements for school-age children.[66] Contrarily, the MSPHA provides significantly greater detail on these public health activities.[67] MSPHA details the requirements for vaccination programs, the provision of vaccines, vaccination clinics, school vaccination

[60] MSPHA § 5-106[b]
[61] MCA § 50-16-1007
[62] MCA § 50-17-105
[63] MCA § 50-18-107
[64] MCA § 50-19-103
[65] MCA § 50-19-203
[66] MCA § 20-5-403
[67] MSPHA § 5-109

programs, and the procurement of vaccines. It also lists circumstances that could exempt an individual from a vaccination program.

A lack of guidance regarding vaccinations and immunizations could lead to conflict and great difficulty if a vaccination program is needed to prevent the spread of contagious disease. Vaccination and immunization efforts may be statutory addressed on a larger scale beyond school-based programs, specifically including program requirements, authorization to provide vaccines, vaccination certification steps, and the conditions for individual exemption from being vaccinated.

Public Health Emergencies

A section of the MT Code is devoted to emergency planning and services.[68] It provides for an emergency and disaster management system,[69] statewide planning,[70] emergency powers and authority[71] and the management of property (evacuation).[72] It also prioritizes the protection of individuals during an emergency situation.[73] This section on disaster and emergency services is comprehensive and detailed, but does not incorporate some potentially important considerations concerning public health emergencies. For example, the focus of the MT Code section is on general emergencies but not specifically public health emergencies or potential public health dangers resulting from an emergency situation. When compared to Article VI of the MSPHA (Public Health Emergencies), additional key distinctions are noted.

First, while Montana has an established emergency planning system, it does not have a public health emergency plan that would allow public health officials to respond specifically to a threat through isolation, quarantine, evacuation, treatment, vaccination and other necessary measures. Such a plan is outlined in the MSPHA[74] and requires the appointment of a public health emergency planning commission to aid in the statewide plan. Additionally, while Montana gives the governor the authority to declare a state of emergency or disaster,[75] the Code does not specifically address the declaration of a state of public health emergency as described in the MSPHA.[76] The necessary emergency powers granted to the governor would be similar in a general emergency or disaster and a public health emergency, but the Code may specify when assistance by public health officials is needed. Furthermore, while the Code gives the governor the authority to manage property, it does not specifically address the control of roads and other public areas, the safe disposal of infectious materials and human remains or the control of healthcare supplies, all of which may be essential in managing a public health emergency. Finally, the MT Code prioritizes the protection of individuals, but does not address public health needs specifically and could include information on the emergency licensing and appointment of

[68] MCA § 10-3
[69] MCA § 10-3-101
[70] MCA § 10-3-301
[71] MCA § 10-3-302 and § 10-3-305
[72] MCA § 10-3-104
[73] MCA § 10-3-101
[74] MSPHA § 6-101
[75] MCA § 10-3-302 and 10-3-303
[76] MSPHA § 6-102

health personnel and could also provide for access to mental health support personnel, as detailed in the MSPHA.[77]

Please note that the findings and recommendations stated above are based solely on a review of statutory and administrative public health laws in Montana, as well as the authors' limited, additional knowledge of the Montana public health system. We acknowledge that other factors underlie whether to proceed with statutory proposals in furtherance of these recommendations, including political factors and how public health is actually practiced in the state regardless of specific laws. Please let us know if you have any questions, comments, or needed clarifications of any of the statements or corresponding research.

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[77] MSPHA § 6-104